RENASYS

Negative Pressure Wound Therapy Systems

Order/prescription form & Patient Assistance Program:

Fax to: 205-942-5094 Phone: 205-942-2650

Smith+Nephew

RENASYS◊
Negative Pressure Wound Therapy System

PLEASE NOTE: ADDITIONAL DOCUMENTATION REQUIRED- PLEASE FAX THE PATIENT'S FACE SHEET.

Patient information:

First and last name: _____ **DOB:** _____

Address: _____

Phone: _____ **Gender:** ☐ **Male** ☐ **Female** **Medicaid Yes or No #**_____

Do you currently have public or private insurance? ☐ **Yes** ☐ **No** **Are you a U.S. Military Veteran?** ☐ **Yes** ☐ **No**

Financial information: **(if amount is $0, please indicate $0 – do not leave blank)**

Total annual household income: _____ **Number in household:** _____ (to include spouse, legal guardian and dependent)

Extraordinary medical expenses: _____

Explanation of extraordinary medical expenses: _____

Additional considerations for receiving patient: _____

_____ _____

Patient or legal guardian signature **Date** **Printed name if legal guardian**

I understand the above information is being provided to Smith+Nephew, Inc., or its assigned agent, with the intent of receiving financial assistance for the Negative Pressure Wound Therapy I have been prescribed. I understand that Smith+Nephew, Inc. has the right to verify this information and to request additional proof or documentation. I authorize Smith+Nephew, Inc. to use and/or disclose this information to verify if I am eligible to participate in the patient assistance program and understand that such verification may include contacting me, my physician and affiliated healthcare personnel, and/or any current insurance provider for additional information. I further understand that based on a review of the information provided, I may still have a financial liability (e.g. office visit copay). I swear, or affirm that the above information is true and correct to the best of my knowledge.

☐ **Pressure ulcer(s)** ☐ **Diabetic ulcer(s)** ☐ **Venous ulcer(s)** ☐ **Arterial** ☐ **Surgical** ☐ **Other** _____

Wound location: Length: _____ Width: _____ Depth: _____

Dressing kit type: ☐ Foam ☐ Gauze **Dressing size:** ☐ Small ☐ Medium ☐ Large

Other supplies: ☐ Y connector ☐ White foam ☐ Transparent film

I prescribe therapy for: ☐ 1 month** ☐ 2 months** ☐ 3 months** Diagnosis: _____

**Please Note: Each prescription is limited up to a 3 month supply, up to 15 dressings per wound and up to 10 canisters per month (unless otherwise specified). A separate request will need to be submitted if additional product is required beyond the initial request.

Licensed HHA or provider that will manage the patient's outpatient wound care: _____ **Phone:** _____

Delivery Address: (Please do not use a PO Box; for RENASYS delivery to hospital; **include the patient's room number and discharge point of contact**)

☐ **Home** ☐ **Hospital, Room#:** _____ ☐ **Clinic** **Date needed/Discharge date:**

_____ _____

Provider information: ORIGINAL SIGNATURE AND DATE REQUIRED

Facility name: _____ **Date:** _____

Full address: _____

Phone: _____ **Fax:** _____ **NPI#:** _____

By signing and dating, I attest that the person listed above is my patient for whom I have prescribed the Smith+Nephew NPWT system as medically necessary. I have read and understand all safety information and other instructions for use included with therapy clinical guidelines. I further certify that I have received the necessary written authorization to release the medical and/or other patient vvvvvveligibility for the assistance program.

_____ _____

Treating prescriber name printed **Date** **Treating prescriber signature**

Referral contact name: _____ **Phone:** _____